# Supreme Court of the United States

OCTOBER TERM, 1976
No. 76-1412



John Borland, Jr., J. Barron Leeds, Louis Polevoy, Irving Kaplan, Irving Levy, John Niccollai, as trustees of the Welfare Fund of Local 464, Amalgamated Meat Cutters Food Store, Employees Union, AFL-CIO and Howard Marks,

*Petitioners,*

*vs.*

Bayonne Hospital, Bergen Pines County Hospital, Beth Israel Hospital, Clara Maass Memorial Hospital, Englewood Hospital Association, Greater Paterson General Hospital, Hackensack Hospital, Irvington General Hospital, Holy Name Hospital, The Hospital Center at Orange, Monmouth Medical Center, Morristown Memorial Hospital, Mountainside Hospital, Newark Beth Israel Medical Center, Riverdell Hospital, Saddle Brook Hospital, Saint Barnabas Medical Center, St. Michael's Medical Center, South Amboy Memorial Hospital, St. Joseph's Hospital, St. Mary's Hospital of Hoboken, St. Mary's Hospital of Passaic, The Blue Cross-Blue Shield Plan of New Jersey, a corporation of the State of New Jersey,

*Respondents.*

ON PETITION FOR WRIT OF CERTIORARI TO THE SUPREME COURT OF NEW JERSEY

# BRIEF IN OPPOSITION TO PETITION FOR WRIT OF CERTIORARI

BRUCE D. SHOULSON,
*Attorney for Defendant-Respondent, Hospitals (Other than Saddle Brook Hospital)*
744 Broad Street,
Newark, New Jersey 07102

*Of Counsel*
LOWENSTEIN, SANDLER,
BROCHIN, KOHL & FISHER

*On the Brief*
BRUCE D. SHOULSON
R. BARRY STIGER

N.J. Appellate Printing Co., Inc., South Plainfield, New Jersey (201) 753-0200

# TABLE OF CONTENTS

TABLE OF CONTENTS

CASES CITED:





TABLE OF CONTENTS

CASES CITED:

TABLE OF CONTENTS





TABLE OF CONTENTS

IN THE

# SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1977

No. 76-1412

John Borland, Jr., J. Barron Leeds, Louis Polevoy, Irving Kaplan, Irving Levy, John Niccollai, as trustees of the Welfare Fund of Local 464, Amalgamated Meat Cutters Food Store, Employees Union, AFL-CIO and Howard Marks,

*Petitioners,*

vs.

Bayonne Hospital, Bergen Pines County Hospital, Beth Israel Hospital, Clara Maass Memorial Hospital, Englewood Hospital Association, Greater Paterson General Hospital, Hackensack Hospital, Irvington General Hospital, Holy Name Hospital, The Hospital Center at Orange, Monmouth Medical Center, Morristown Memorial Hospital, Mountainside Hospital, Newark Beth Israel Medical Center, Riverdell Hospital, Saddle Brook Hospital, Saint Barnabas Medical Center, St. Michael's Medical Center, South Amboy Memorial Hospital, St. Joseph's Hospital, St. Mary's Hospital of Hoboken, St. Mary's Hospital of Passaic, The Blue Cross-Blue Shield Plan of New Jersey, a corporation of the State of New Jersey,

*Respondents.*

---

Respondent hospitals pray that the Court deny the petition for a writ of certiorari to review the decision of the Supreme Court of New Jersey affirming the decisions of the Superior Court of New Jersey, Chancery Division and Appellate Division.

## QUESTION PRESENTED

Does state action which permits the creation of non-profit, closely regulated hospital prepayment plans, and permits such plans to be charged less than other hospital

users for the same hospital services, all in order to encourage a broad based community health program, violate the Fourteenth Amendment to the United States Constitution?

## STATEMENT OF THE CASE

By their petition for a writ of certiorari, petitioners challenge the favorable rate structure which exists under New Jersey law for nonprofit hospital service corporations, such as Hospital Service Plan of New Jersey ("Blue Cross"), as a means of encouraging the general public to purchase insurance for hospital care. The petition has been consolidated with a petition in a companion case brought by petitioners against the Commissioners of Insurance and Health of the State of New Jersey ("Commissioners") in which petitioners allege that the Commissioners have improperly discharged their statutory functions in establishing the Blue Cross reimbursement rates.

Respondent hospitals submit that on the basis of well-founded and long-standing decisions of this Court, *see, e.g. City of New Orleans v. Dukes*, – U.S. – (1976) 44 U.S.L.W. 5074 (U.S. June 22, 1976), none of the reasons advanced by petitioners raises any special and important issue which this Court, in the exercise of its sound judicial discretion, should review (S.Ct. *Rule* 19).

*New Jersey Cost Reimbursement System:*

A review of the applicable New Jersey statutory frame-work and administrative process is necessary to an analysis of petitioners' contentions.

In order to encourage broad segments of their populations to achieve security from medical indigency by budgeted prepayments, New Jersey and most other states



have adopted legislation authorizing the creation of tax-exempt hospital service corporations, the largest group of which is generally known as Blue Cross. Hospital Service Corporation Act, *N.J.R.S.* 17:48-1, *et seq.*; *see Associated Hospital Service, Inc. v. Milwaukee*, 13 Wis. 2d 447, 109 N.W. 2d 271, 88 A.L.R. 2d 1395 (1961). In New Jersey, Blue Cross contracts with group and individual subscribers to provide hospital services. Contracts with subscribers are subject to statutory regulation and the contracts and rates charged are subject to disapproval by the Commissioner of Insurance. *See N.J.R.S.* 17:48-6, 6.1-6.9, 8 and 9. Blue Cross also contracts with health care facilities such as respondent hospitals for the rendering of health care services to subscribers at per diem rates (reimbursement rates), unique to each such facility, which rates are approved as to reasonableness by the Commissioner of Insurance following certification made pursuant to section 18 of the Health Care Facilities Planning Act, *N.J.R.S.* 26:2H-1, *et seq*. The statutory and administrative framework for the determination of such reimbursement rates is at the crux of petitioners' allegations of unconstitutionality. But, as discussed in detail below, respondent hospitals are not in any way responsible for the challenged statutory and administrative framework.

*N.J.R.S.* 26:2H-18 provides in pertinent part as follows:

> "c. The Commissioner of Health in consultation with the Commissioner of Insurance shall determine and certify the costs of providing health care services, as reported by health care facilities, which are derived in accordance with a uniform system of cost accounting approved by the Commissioner of Health. Said certification shall specify the elements and details of costs taken into consideration.

> "d. Payment by hospital service corporations . . . for health care services provided by a health care facility shall be at rates approved as to reasonableness by the Commissioner of Insurance with the approval of the Commissioner of Health. In establishing such rates, the commissioners shall take into consideration the total costs of the health care facility."

In practice, until 1975 the rate-making process involved the appointment of a Budget and Advisory Committee to which New Jersey hospitals, each October or November, submitted their proposed operating budgets for the coming calendar year on forms provided by the Commissioner of Insurance. The Committee was organized by an affiliate of the New Jersey Hospital Association to assist the Commissioners in evaluating budgets. The forms provided for the exclusion of certain costs based on policy decisions made by the Commissioner of Insurance.

Prior to 1975, the Advisory Committee recommended to the Commissioner of Insurance for his approval a tentative per diem reimbursement rate for the operating year for each hospital. The reimbursement rate is an all-inclusive one which, as part of the health care financing system envisioned by the statute, does not necessarily relate to utilization of particular hospital facilities or services. This is in contrast to the hospitals' established charges to the public which are based on actual utilization. Beginning with 1975, the Commissioner of Health instituted a new system which does away with the Budget and Advisory Committee and relies on strict budgetary controls as administered by the staff of the Department of Health. *See N.J.A.C.* 8:3-1, *et seq.*



Under both the systems in force prior to 1975 and thereafter, the reimbursement rates as finally determined by the Commissioners have not fully reimbursed contracting hospitals for all costs incurred. The deficiencies are due to the Commissioners' exclusion of certain costs as being unreasonably incurred or in categories not eligible for reimbursement. In addition, the losses resulting from care rendered to indigents are not considered in the rate calculation. As a result, in order to recover the costs and losses not otherwise reimbursed, New Jersey hospitals, such as the respondents in the instant case, are forced to charge those patients who are not participants in cost reimbursement programs, such as Blue Cross, Medicare and Medicaid, rates in excess of so-called cost. Private insurance carriers, welfare funds such as those administered by petitioner trustees and uninsured patients comprise the group required to pay the higher charges.

*Proceedings Below:*

Petitioners, Trustees of the Welfare Fund of Local 464, Amalgamated Meat Cutters Food Store, Employees Union, AFL-CIO (hereinafter "Union") and Howard Marks, alleged to be a union member and eligible beneficiary of the Union Welfare Plan, originally instituted the within action against 22 New Jersey hospitals, the Commissioners of Health and Insurance, and Blue Cross. The petitioners sought injunctive relief and damages for alleged discrimination by respondent hospitals in charging petitioners at higher rates for hospital services than are permitted by the Commissioner of Insurance for reimbursement for similar services rendered to Blue Cross subscribers (P7a-13a).[1]

1. References in this brief to the petition will be indicated by a "P" followed by the page number, while references to petitioners' appendix will be indicated in the same manner but with an "a" following the page designation.

In separate counts of the Complaint which are only relevant to the petition in the companion case before this Court, petitioners alleged: (i) that the approval by the Commissioner of Insurance of the Blue Cross rate of reimbursement of respondent hospitals constituted a denial by the Commissioner of Insurance of petitioners' rights to equal protection of the laws and to due process of law in contravention of the provisions of the Fourteenth Amendment to the United States Constitution (P13a-14a); and (ii) that the Commissioners of Health and Insurance, respondents in the companion case, have acted illegally and in a discriminatory and unfair manner in their approval of the rate of reimbursement of respondent hospitals by failing to take into account all of the costs of the health care facilities as required by *N.J.R.S.* 26:2H-18(d) (P16a-17a).

Respondent hospitals moved in the trial court to dismiss the Complaint as it related to them, and specifically to dismiss the counts of the Complaint which alleged that their activities violated plaintiffs' rights under the Fourteenth Amendment. The motion to dismiss was based on the premise that so far as the respondent hospitals were concerned, the factual and legal basis of the case was completely contained in the Complaint, the Hospital Service Corporation Act, *supra*, and the Health Care Facilities Planning Act, *supra*. The hospitals conceded the existence of the differential but pointed to the fact that under the applicable statutes, the Commissioners had the authority to fix the Blue Cross reimbursement rate. Accordingly, the hospitals argued that if petitioners were prejudiced by the rates set by the Commissioners, they should pursue their remedy against the Commissioners and not against hospitals which had no control over the situation.



After reviewing the extensive briefs filed by the parties and considering their oral arguments, the trial court treated the hospitals' motion as a motion for summary judgment and ruled that as a matter of law neither Blue Cross nor the respondent hospitals control the Blue Cross reimbursement rate, since that function is vested by statute in the Commissioner of Insurance, subject to the approval of the Commissioner of Health (P37a). Accordingly, the trial court found there to be no issue of fact before it, and in the judgment of the Court, the issues presented by respondent hospitals' motion were legal in nature only. As to the omission of certain costs from the Blue Cross reimbursement formula, the trial court held that not to be an issue between petitioners and the hospitals and Blue Cross but rather an issue between petitioners and the Commissioners of Health and Insurance (P39a).

The Commissioners of Health and Insurance did not move to dismiss the Complaint as to them and the trial court ruled that the action was to proceed solely against the Commissioners on the issues relating to their enforcement of the applicable statutes. In fact, the Court noted in its opinion that the respondent hospitals had reserved for themselves the right to proceed against the Commissioners on the same issue raised by petitioners, namely, the Commissioners' failure to adhere to the statutory requirements and consider all costs in determining the applicable Blue Cross reimbursement rate (P39a).

As the basis for upholding the constitutionality of the legislative structure establishing hospital service corporations such as Blue Cross, and regulating their operations, the Court found the statutory pattern to bear a reasonable relationship to the permissible legislative objective of establishing a broad-based community health program (P42a).

On April 13, 1973 petitioners filed their Notice and Appeal from the decision of the trial court (P55a).

On July 3, 1975 the Superior Court of New Jersey, Appellate Division unanimously affirmed the entry of summary judgment in favor of respondent hospitals and Blue Cross. (P81a).

On August 15, 1975 petitioners filed a Notice of Appeal to the Supreme Court of New Jersey (P130a).

On January 13, 1977 the New Jersey Supreme Court unanimously affirmed the judgments of the Courts below (P18).

On April 13, 1977 petitioners applied to this Court for a writ of certiorari to the Supreme Court of New Jersey.



## ARGUMENT

### I. THE STATUTORY PROGRAM ENACTED AND ADMINISTERED TO SECURE BROAD COMMUNITY HEALTH INSURANCE COVERAGE AT MODERATE COST WHICH HAS THE EFFECT OF PERMITTING BLUE CROSS TO REIMBURSE PARTICIPATING HOSPITALS AT RATES WHICH ARE LOWER THAN PETITIONER — NONSUBSCRIBERS' RATES FOR THE SAME SERVICES DOES NOT VIOLATE THE FEDERAL CONSTITUTION.

In the various proceedings in this matter before the New Jersey courts, petitioners took the position that the statutory scheme which established Blue Cross and is the basis for the existing regulatory system itself violated the Federal Constitution (P40a). The constitutional issues raised by petitioners were extensively treated in the opinion of the trial judge (P32a, *et seq.*) which in turn was relied upon by the eight appellate judges who subsequently reviewed and unanimously affirmed the trial judge's decision in this case.

By contrast, in their petition to this Court, petitioners have seemingly altered their approach and now focus their argument on what they allege to be an unconstitutional *administration* of the statutory system. Petitioners allege that by permitting Blue Cross to pay for hospital services on a preferential basis, the Commissioners have created an improper classification of hospital payers. One class of such payers (*e.g.*, Blue Cross) is not required to carry the burden of certain hospital costs, while another class (*e.g.*, petitioners) is forced to pay these costs, and thus "de facto subsidize" the first class (P10). According

to petitioners, there is no basis in law for this unequal treatment.[2]

Notwithstanding what purports to be a different constitutional challenge, the equal protection argument advanced by petitioners before this Court is essentially identical to that presented to the New Jersey courts and the decisions of those courts apply with equal force and effect to refute petitioners' position.

As noted in the opinion of the trial court, the decisions of this Court have conclusively established that the state has the unquestioned power to legislate in the area of public health. *Williamson v. Lee Optical of Okla.*, 348 U.S. 483 (1955). Equally well-established is the fact that in the field of insurance, "the power of the state is broad enough to take over the whole business, leaving no part for private enterprise." *California Auto. Asso. v. Maloney*, 341 U.S. 105, 110 (1951); *Osborn v. Ozlin*, 310 U.S. 53, 66 (1940).

In New Jersey, rather than preempt the health insurance field entirely, *cf. Independent Service Corporation v. Tousant*, 56 F. Supp. 75 (D. Mass. 1944), *aff'd*, 149 F.2d 204 (1st Cir. 1945), the Legislature has chosen to enact the Hospital Service Corporation Act, *supra*, which is designed particularly to accomplish the purpose of a broad based community health program, *i.e.*, to satisfy the needs of the hospitals and the community as a whole through a partnership between hospitals and nonprofit prepayment plans. The goals and objectives of this partnership are

2. Petitioners have also argued that the Commissioners have violated the statutory mandate which "requires" them "to consider the total costs necessary to maintain solvency of respondent hospitals." (P10). This is a question of State law and the final authority to determine the issue resides with the New Jersey courts. In its opinion, the Supreme Court of New Jersey held that the method of calculation "does take into consideration the total expenses of the hospital. . . ." (P24). Thus, this issue has been determined and is not properly before this Court.



(a) to provide to the public a payment-in-advance method for financing care provided by hospitals and to guarantee payment to the hospitals; (b) to make hospital care needed by the public financially accessible to the largest number of people at the lowest possible cost; and (c) to help the community carry the social and economic burden created when people are unable to pay for the necessary care rendered by hospitals (P43a).

Petitioners, however, are not involved in this partnership and therefore are not subject to the same burdens, restrictions and public control of their operations which membership in the partnership entails. These burdens include limitations on administration expenses (*N.J.R.S.* 17:48-10), restrictions on investments (*N.J.R.S.* 17:48-10), requirements as to composition of board of directors (*N.J.R.S.* 17:48-5), limitations on termination of coverage, refusal to renew coverage, selection of risks and underwriting classifications (*N.J.R.S.* 17:48-6), and other limitations described by the trial court (P43a). One can only speculate as to what petitioner welfare fund's response would be if State legislation were enacted imposing controls on the benefits it must offer, its spending and investment activities and its other operations similar to the controls imposed on Blue Cross under existing law. If petitioner trustees believe they are being discriminated against because of their refusal to participate in the Blue Cross program and their endeavor to establish their own more expensive program, then they only need apply to become a part of the Blue Cross group. In demanding that the hospitals charge them the same rate as Blue Cross, petitioners seek only the advantage of the comprehensive regulatory scheme without assuming any of the concomitant burdens associated with detailed regulation of their operations in the public interest, such as those outlined above.

The union welfare fund operates for the private interest of the individual members and not, as Blue Cross, for the benefit of the public at large. The clear factual differences in purpose and operation between Blue Cross and the union welfare fund make the difference in classification for hospital reimbursement purposes a permissible one under the Constitution. In fact, petitioners have failed to appreciate the importance of the continued existence of the Blue Cross (and Medicare) systems to the continued control of health facility costs in view of the fact that, without Blue Cross or Medicare, many patients whose hospital bills are paid by Blue Cross or Medicare might not be able to pay part or any of their hospital bills, thus increasing the "burden" of caring for indigents far beyond the reimbursement differential. See the reference to the coverage of poor risk subscribers in *Travelers Ins. Co. v. Blue Cross of West Pennsylvania*, 481 F.2d 80, at 82 n.8 (3d Cir. 1973), *cert. denied*, 414 U.S. 1093 (1973).

In summary, the petitioners' complaint of an invalid legislative or administrative classification flies in the face of well-established and unquestioned constitutional principles. The fact that the Legislature classifies hospital service corporations differently from other third party payers and private patients with regard to the reimbursement of the hospitals is "not palpably arbitrary" but is "reasonably based on a substantial difference or distinction" which is "rationally related to a legitimate statutory objective or purpose." [3] Not every inequality offends the constitutional provisions of due process and equal protection. *City of New Orleans v. Dukes, supra* (The Court in up-

3. Similarly, Congress has required that payments to participating hospitals for hospital services to Medicare beneficiaries be made solely on the basis of "reasonable costs" rather than on the basis of charges to the public. 41 U.S.C.A. §1395f(b); 20 C.F.R. §405.401(a).



holding an economic regulation stated that "[s]tates are accorded wide latitude in the regulation of their local economies under their police powers, and rational distinctions may be made with substantially less than mathematical exactitude." *Id.* at 5076); *Dandridge v. Williams*, 397 U.S. 471, 485 (1970); *Lindsley v. Natural Carbonic Gas Co.*, 220 U.S. 61, 78-79 (1911).

The recent case of *Travelers Ins. Co. v. Blue Cross of West Pennsylvania*, *supra* at pp. 85 and 86, quickly rejected the argument that the reimbursement differential between Blue Cross and private hospital payers violated the equal protection requirement. *Cf. Clarke v. Redeker*, 259 F. Supp. 117, 122 (S.D. Iowa 1966) in which it was held that it is constitutionally permissible for a state university to charge non-residents higher tuition than residents as a reasonable attempt to achieve the permissible goal of cost equalization.

Petitioners have failed to carry the burden of showing that the classification, legislative or administrative, which results in favorable benefits to hospital service corporations such as Blue Cross does not bear a reasonable relation to a permissible legislative objective, *West Coast Hotel Company v. Parrish*, 300 U.S. 379, 391 (1937), and is essentially arbitrary. *Goldblatt v. Town of Hempstead*, 369 U.S. 590 (1962); *Lindsley v. Natural Carbonic Gas Co.*, *supra* at 78-79. If any state of facts reasonably may be conceived to justify the distinction, the statute will be upheld. *City of New Orleans v. Dukes, supra; Usery v. Turner Elkhorn Mining Co.*, 428 U.S. 1 (1976); *Dandridge v. Williams*, *supra* at 486-87, *Metropolitan Casualty Ins. Co. v. Brownell*, 294 U.S. 580 (1935). Specifically, petitioners have failed to demonstrate that the Legislature, in writing enabling legislation for hospital service corporations, and the Commissioners in administering the legislation, have estab-

lished an arbitrary classification of the respective groups and that the statutorily sanctioned difference in treatment of Blue Cross (the largest hospital service corporation in New Jersey) bears no rational relation to legitimate legislative objectives.

Whether the State has chosen wisely or foolishly in creating and regulating Blue Cross in its relationship with the hospitals is not a concern for this Court; it is sufficient that the objective—community-wide health financing—is permissible and the scheme reasonably related to the objective. *See Osborn v. Ozlin, supra.*

In *Associated Hospital Service, Inc. v. Milwaukee, supra*, the Wisconsin Supreme Court considered whether the tax exemption granted the Blue Cross plan resulted in an unreasonable classification violative of the equal protection clause of the Fourteenth Amendment. In particular, the City of Milwaukee argued that an arbitrary and unconstitutional classification is made by the statute in granting exemption to the property of Blue Cross and not to that of insurance companies. The court, after discussing the history and background of Blue Cross and the purposes and objectives to which it is dedicated, noted the "marked difference in method of operation between a Blue Cross hospital service corporation and a commercial insurance company that sells hospital care indemnity insurance." 88 A.L.R. 2d at 1411. The court said:

> "The state's interest in protecting the financial status of its state, county, municipal, and voluntary nonprofit hospitals is a further justification for treating Blue Cross hospital service corporations differently taxwise than it does commercial insurance companies writing hospital care indemnity insurance." *Id.* at 1412.



The court concluded:

> "Enough has been said to indicate that the classification made by (the statute) does rest upon real differences existing between non-profit hospital service corporations and commercial insurance companies writing hospital care indemnity insurance. Therefore, such statute does not impose an arbitrary unreasonable classification and is constitutional." *Id.*

For purposes of this petition it may be assumed *arguendo* that petitioner-trustees, in attempting to provide a health service benefits program to members of the union, are at a competitive disadvantage vis-a-vis Blue Cross to the extent that the latter pays less per patient than the petitioner-trustees. However, given the public and quasi-public nature of the entire hospital service corporation system—especially the Blue Cross-member hospital relationship as controlled and regulated by the Commissioners—it is apparent that the trustees are complaining of an unequal competitive environment created by and maintained by the State. No constitutional doctrine requires that the State permit free competition or refrain from competing with private concerns especially in an area of such public concern as health financing for the community. *Cf. Tennessee Electric Power Co. v. T.V.A.*, 306 U.S. 118, 138-40 (1939) (private utility complains of T.V.A. competition and T.V.A.'s ability to offer lower rates); *Madera Waterworks v. Madera*, 228 U.S. 454, 456 (1913); *Helena Waterworks Co. v. Helena*, 195 U.S. 383, 388 (1904); *Joplin v. Southwest Missouri Light Co.*, 191 U.S. 150 (1903). *Cf. Hardin v. Kentucky Utilities Co.*, 390 U.S. 1 (1968) (T.V.A. competition).

Notwithstanding its power to do so, in creating hospital service corporations and in regulating their reimbursement of hospitals, the State of New Jersey has not sought to forbid or destroy competition among other organizations wishing to provide health insurance or health

service benefits. Neither has the State required all persons to purchase Blue Cross insurance or forbidden others to act as third party payers. Rather, the statute creating the Blue Cross program provides certain benefits to and imposes certain burdens on Blue Cross so as to enable it to accomplish its statutory purposes. The fact that in so doing the petitioners' welfare plan has been put at a competitive disadvantage does no violence to the Constitution. *Cf. City of New Orleans v. Dukes, supra; Independent Service Corporation v. Tousant, supra. See also Virgo Corporation v. Paiewonsky*, 384 F.2d 569 (3d Cir. 1967), *cert. denied*, 390 U.S. 1041 (1968) (one of four competitors may be denied subsidies granted to others where, in view of public purpose of subsidy program, classification was not "patently arbitrary").

Respondent hospitals' contentions do not relate to the issues pertinent to the companion case, *Borland v. McDonough*, 135 N.J. Super. 200 (App. Div. 1975), *aff'd*, 52 N.J. 152 (1977), *petition for cert. filed*, 45 U.S.L.W. 3707 (U.S. April 26, 1977), and which are set forth in the Fourth and Fifth Counts of the Complaint where it is alleged that the particular rates approved by the Commissioners fail to take into account certain items of necessary hospital expenses. The hospitals themselves have reserved the right to raise these same issues regarding the elimination of costs at the appropriate time in actions solely against the Commissioners of Insurance and Health and against Blue Cross.[4]

4. At least two New Jersey hospitals have in fact instituted suit with respect to disallowance by the Commissioners of eligible costs for previous years. *Newark Beth Israel Medical Center v. Sheeran*, Docket No. A-785-74 (App. Div. Super. Ct., June 11, 1976); *West Jersey Hospital v. Hospital Service Plan of New Jersey*, Docket No. A-2002-74 (App. Div. Super. Ct.).



## II. ALL PARTIES HAVING ADMITTED THE EXISTENCE OF A DIFFERENTIAL BETWEEN THE BLUE CROSS REIMBURSEMENT RATE AND THE CHARGES TO NONSUBSCRIBERS, AND PETITIONERS HAVING FAILED TO SHOW (I) THE EXISTENCE OF ANY GENUINE MATERIAL ISSUES OF FACT AND (II) ANY CONNECTION BETWEEN THE HOSPITALS AND THE ALLEGED ARBITRARY EXCLUSION OF COSTS BY THE COMMISSIONERS OF HEALTH AND INSURANCE, THE LOWER COURTS WERE CORRECT IN VIEWING THE CASE AS APPROPRIATE FOR DISPOSITION ON RESPONDENT HOSPITALS' MOTION TO DISMISS.

In moving before the trial court to dismiss petitioners' Complaint as to them, respondent hospitals conceded the differential in rates and contended that since the rates are set by the Commissioners, as a matter of law this differential gave rise to a claim against the Commissioners but not against respondent hospitals. Petitioners have failed to show how discovery of the precise elements of cost which result in the rate differential or how discovery of the elements excluded from the Blue Cross reimbursement rates would have had any impact on the decision of the trial court in granting summary judgment in favor of respondent hospitals.

With respect to the resolution of petitioners' complaint against respondent hospitals, it is sufficient that the hospitals admit the differential between the rate charged petitioners and the Blue Cross rate. The fact that respondent hospitals are affected by the Blue Cross reimbursement rates and are required to submit data used in

the rate-making process does not lead to the conclusion that the hospitals are parties with respondent Commissioners in an allegedly unconstitutional administration of the statutory scheme. Any allegation of such concerted activity or commonality of purpose and action flies in the face of all logic and was in fact found by the trial judge to be "spurious" (P39a). The decisions in the courts below not permitting petitioners discovery were based upon New Jersey court rules and case law which comply with the due process requirements of the Fourteenth Amendment. *Cf. Banco De Espana v. Federal Reserve Bank of New York*, 28 F. Supp. 958 (S.D. N.Y. 1939), *aff'd.*, 114 F.2d 438 (2d Cir. 1940); *Beidler & Bookmyer v. Universal Ins. Co.*, 134 F.2d 828 (2d Cir. 1943).

Reason dictates that rather than seeking to exclude costs, the hospitals would do everything in their power to have all costs considered and included in establishing the reimbursement rate. It is *against* the interests of the hospitals to agree to rates which result in recovery of less than all costs. For many hospitals, particularly those in large urban areas, the charges paid by non-Blue Cross subscribers are not nearly sufficient to cover the deficits resulting from losses incurred in treating the indigents which are not included in the Blue Cross reimbursement rate calculation.

Petitioners, without any supporting evidence, attempt to portray the Commissioners as inactive rubber stamps of the decisions of the hospitals and Blue Cross, and as performing mere ministerial functions in computing rates. This portrayal illustrates either a complete naivete as to the Commissioners' role in the Blue Cross process or a conscious attempt by petitioners to divert the Court's attention from the realities of the situation. In fact, the hospitals and Commissioners have been involved in virtually continuous disputes regarding certification of costs and establishment of reimbursement rates. Far from automatically approving the hospitals' rate requests, the Commissioners have forced hospitals into greater deficits by refusing to permit reimbursement for costs certified to have been incurred in categories eligible for reimbursement.



The basis to be used by the Commissioners in disallowing certified costs for 1975 was the essence of *Monmouth Medical Center v. State of New Jersey*, Docket No. A-2147-2154-74 (App. Div. Super. Ct., April 30, 1975) cited by petitioners (P8). In addition, at least two suits have been instituted by other hospitals (one a respondent in this case) with respect to the disallowance by the Commissioners of eligible costs for previous years. *Newark Beth Israel Medical Center v. Sheeran, supra; West Jersey Hospital v. Hospital Service Plan of New Jersey, supra.* Also, a new suit was recently instituted by the New Jersey Hospital Association on behalf of virtually all New Jersey hospitals against the Commissioners and Blue Cross seeking certification and full payment of reimbursable costs for the years 1971 through 1975. *New Jersey Hospital Association v. Hospital Service Plan of New Jersey*, Docket No. L-24750-76 (Super. Ct. Law Div., filed February 28, 1977).

Thus, far from being conspirators in a plot to depress Blue Cross reimbursement rates, the hospitals have been and continue to be the unwilling victims of the Commissioners' lack of responsiveness to the hospitals' needs. The hospitals receive no benefit from lower reimbursement rates, nor have petitioners attempted to cite any motive for the alleged conspiracy to depress such reimbursement rates. On the contrary, higher reimbursement rates are sought by every hospital. Any increase in reimbursement rates, however, must be reflected in increased premium charges to subscribers. Because of the vast number of

Blue Cross subscribers in New Jersey, any potential premium increase is fraught with substantial political and economic significance and receives front-page newspaper coverage throughout the State.

Thus, the Commissioners' refusal to permit hospitals to receive a rate which actually reimburses for costs is not the result of an abdication of a statutory function, but is an expression of a conscious political decision based on the simple fact that there are less than 150 hospitals in New Jersey, but approximately 4.4 million Blue Cross premium payers within the State. Any complaint which petitioners may have should therefore be addressed to the Commissioners in the companion case.

In addition to raising the specious issue of conspiracy and accusing the Commissioners of Health and Insurance of abdicating their responsibilities and permitting the hospitals and Blue Cross together to set the reimbursement rates, petitioners claim that other issues of fact exist since it must be determined what items are excluded in the establishment of the rate and why such items are excluded. While surely these are issues of fact relevant to the proceeding between petitioners and the Commissioners, they have no relevance to any claim which petitioners have against respondent hospitals. The hospitals have conceded the omission of certain items of cost in the determination of the reimbursement rate. The items were omitted, properly or improperly, by virtue of policy decisions made by the Commissioners of Health and Insurance who have been given the power by the Legislature to fix the rates. Why the Commissioners sought to exclude certain items is a matter that has no bearing on petitioners' claims against respondent hospitals.

Thus, it is submitted that petitioners have failed to establish the existence of any issues of fact warranting denial of respondent hospitals' motion to dismiss.



## CONCLUSION

On the basis of the foregoing, it is respectfully submitted that the petitioners have failed to demonstrate any claim against the respondent hospitals appropriate for review by this Court. Any issues raised by petitioners relate only to the administration of the statutory scheme by the Commissioners of Health and Insurance. Accordingly, the instant petition for a writ of certiorari to the Supreme Court of New Jersey should be denied.

Respectfully submitted,

BRUCE D. SHOULSON
*Attorney for Defendant-Respondent Hospitals (Other than Saddle Brook Hospital)*

*Of Counsel*
LOWENSTEIN, SANDLER, BROCHIN, KOHL & FISHER
744 Broad Street
Newark, New Jersey 07102

*On the Brief*
BRUCE D. SHOULSON
R. BARRY STIGER